STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
(302) 995-8521
APPLICATION FOR BLUEPRINT REVIEW

I. IDENTIFYING INFORMATION:

OHFLC

PROJECT CODE _____

FACILITY NAME _____
Print

FACILITY ADDRESS _____
ADDRESS 1

_____
ADDRESS 2

_____ _____ _____
CITY STATE ZIP CODE

OWNER _____
Print

_____ _____ _____
EMAIL PHONE NUMBER FAX

ARCHITECT _____
Print

_____ _____ _____
EMAIL PHONE NUMBER FAX

PRIMARY CONTACT _____
Print Name

RELATIONSHIP TO OWNER _____
Print

_____ _____ _____
EMAIL PHONE NUMBER FAX

II. FACILITY TYPE

_____
Print Name

III. REGULATORY DETAILS

CIRCLE: LICENSED CERTIFIED BOTH

IV. SCOPE OF PROJECT

CIRCLE:
1) NEW FACILITY
2) NEW AREA OR SERVICE IN EXISTING FACILITY
3) UPDATE OR UPGRADE TO EXISTING AREA/SERVICE
4) USAGE CHANGE OF AN AREA
5) COSMETIC CHANGES

V. ATTACH A SHORT PROJECT DESCRIPTION TO ENABLE OHFLC TO IDENTIFY THE APPROPRIATE SECTIONS OF THE 2006 Guidelines for Design and Construction of Health Care Facilities.

VI. PLEASE INDICATE WHAT SECTION(S) OF THE 2006 Guidelines for Design and Construction of Health Care Facilities you are requesting authorization to utilize. You *must* complete this section or your application will be returned.

VII. IF SURGICAL FACILITY OR HOSPITAL OPERATING ROOMS, COMPLETE THE FOLLOWING:

		# OF CLASS A ORS/PROCEDURE ROOMS	
# OF PREP/RECOVERY BEDS (DUAL USE)		# OF CLASS ENDOSCOPY ROOMS	
# OF PREP BEDS		# OF CLASS B OPERATING ROOMS	
# OF RECOVERY BEDS		# OF CLASS C OPERATING ROOMS	
		TOTAL NUMBER OF OPERATING ROOMS	

VIII. SIGNATURE OF PERSON COMPLETING THIS APPLICATION AND DATE

DATE Signature

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Reviewed and returned by OHFLC:

DATE Signature

Comments:

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Accepted by OHFLC:

DATE Signature

Comments: